Chicago Public Schools

REFERRAL FOR SUSPECTED ILLNESS

Your child, _____DOB:_____ was referred to the
Student's name

Care Room on _____, as they demonstrate the following symptoms:
Date

□ Fever (100.4 degrees Fahrenheit or higher)
□ Swollen Neck Glands
□ Persistent Cough (runny nose, eye drainage)
□ Difficulty Breathing (short of breath, tight chest)
□ Ear Pain or Discharge
□ Diarrhea (loose-frequent bowel movements)
□ Extreme Pallor (pale)
□ Skin Rash
□ Sore Throat
□ Vomiting
□ Headache
□ Chills
□ Severe Pain/Body Aches
□ Dizziness and Weakness
□ Other (please specify): _____
_____
_____

Because one or more of these symptoms may be a sign of a communicable condition, your child is being medically excluded from school.

We recommend that you contact your Medical Provider [Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA)] for advice.

Please obtain written documentation from your Medical Provider indicating that your child has been evaluated. Documentation must indicate when your child is medically cleared to return to school. The Medical Provider may use page 2 of this form to document your child's diagnosis or determination that the condition is non-infectious and/or non-communicable. Please return this completed form upon the student's return to school.

If you have any questions, please contact the School Nurse:

_____ at _____.
Name of Registered Nurse (CSN/HSN) CPS email address or School Phone Number

Do you need help connecting to insurance or finding a medical provider?

Call 773-553-KIDS Monday-Friday 8 am- 5 pm and we will be happy to assist you.

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Student Name: _____ DOB: _____

To be completed by the student's medical provider

Suspected or confirmed diagnosis of the student's condition: _____

_____

COVID suspected: Yes □ No □

COVID Testing: Yes □ No □ Date: _____ Results: Positive □ Negative □

Treatment prescribed:

_____

Is the condition communicable? Yes □ No □

_____

May this student attend school? Yes □ No□

Date student may return to school: _____

Is follow-up care indicated? Yes □ No □ (If yes, please explain.)

_____

_____

_____

Medical Provider Name:_____

Medical Provider Credentials (circle one): MD DO APRN PA

Hospital or Clinic Affiliation: _____

Address:_____

Telephone #: _____ Fax #:_____

Medical Provider's Signature: _____

Date:_____

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